Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PAIN & LASER CENTER PA
3312 NORTH UNIVERSITY DRIVE SUITE L
NACOGDOCHES TEXAS 75961

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-04-8713-01

MFDR Date Received
April 22, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Clearly, there are no requirements that a surgical center needs to be licensed according to this or any other TWCC rules. Confirmation that nothing is stated in the TWCC guidelines that a facility has to be listed with the Texas Department of Health Facility licensing and Compliance Division was provided by our documented phone conversation with Tom Shirely, a supervisor with Risk Management Services, (attachment 'B'). Title 25, Part 1, Chapter 135, Subchapter A, rule 135.19 titled 'Exemptions' of the Texas Administrative Code (attachment 'C') provided the facilities that are not required to be licensed. B&B Pain Management Facility, since it is a clinic of a licensed physician, Daniel R. Theesfeld, M.D., it is exempt from the requirements of licensure."

Amount in Dispute: $6,775.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The entire bill was denied as out of the scope of the providers [sic] practice - TWCC mapping letter K. Liberty Mutual does not believe that this facility meets the requirements to be reimbursed as a licensed Ambulatory Surgery Center. The provider is billing as a licensed Ambulatory Surgery Center on a UB92. A letter written by Dr. Daniel Theesfled, MD and date March 15, 2004 identifies 'The Pain and Laser Center' as a freestanding Ambulatory Surgical Center to be licensed by the Texas Department of Health. We have no record of this facility, Pain and Laser Center, as being Licensed [sic] by the Texas Department of Health, Health Facility Licensing Division. It does not appear on the Texas Department of Health, ASC Directory Report as being licensed... Liberty Mutual does not believe that The Pain and Laser Center is due any further reimbursement for services rendered to Mr. [injured employee] on date of service 1/26/04."

Response Submitted by: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2004	Revenue Codes: 250, 370, 710, 360	$6,775.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 22, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 27, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 29, 2004
   - B417 – Service is denied. It does not fall within the scope of the providers practice.
   - X392 – Our position remains the same; if you disagree with our decision please contact the TWCC Medical Dispute Resolution
   - Z140 – Insurance carrier payment to the health care provider shall be according to commission medical policies and fee guidelines in effect on the date(s) of service(s).

Findings

1. This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, reimbursement is subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. Former 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration." Review of the submitted documentation finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The requestor submitted the initial billing on a UB92 and upon reconsideration submitted the billed charges on a CMS-1500. The Division concludes that the requestor has not met the requirements of §133.307(e) (2) (A).
4. Former 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g) (3) (B).
5. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's position statement asserts that "B&B Pain Management Facility, since it is a clinic of a licensed physician, Daniel R. Theesfeld, M.D., it is exempt from the requirements of licensure."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.